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Welcome to Our Office

Thank you for choosing our office. In order to serve you properly, PLEASE PRINT the following information.			
Name:			
Address:		City/State/Zip:	
SSN:	Birthdate:	Marital Status:	Gender:
Home Ph:	Work Ph:	Cell Ph:	Fax:
May we contact you by email yes ___ no ___	Email Address:		
Employer:	Address:		
Occupation:	Full/Part/Student/Retired/Other:		
Emergency Contact Name:			Relationship:
ER Contact Home Ph:		ER Contact Work Ph:	
How did you hear about us:		Referring Doctors Name and Phone Number:	
What Procedure(s) are you interested in?			
List Medication(s) you are on and the dosages:			
Insured Party Primary & DOB:		Address:	
Primary Ins	Policy No:	Group No:	
Insured Party Secondary:		Address	
Secondary Ins:	Policy No	Group No:	
If Workers Compensation, treatment authorized by:			Claim #:

I authorize this office to release to the named insurance company any information necessary to expedite insurance payment: I understand that I am responsible for all charges, regardless of insurance coverage.	
Patient, Parent or Guardian Signature:	Date: